Health Care Cost Trends Hearings

6-30-11 PM

Jody Gittell

I apologize that it was such a short lunch break, but we're trying to keep to schedule and hopefully we can all get out of here today at 5 PM. So over the past three-and-a-half days, we've heard common themes from different stakeholders -- everyone from the leaders of our state's largest hospitals to those who represent the consumer voice. The problem of health care cost is real, it's urgent, and it needs to be addressed. It needs to be addressed promptly, but it needs to be addressed with a full understanding of all the dynamics in the current system, including the characteristics that need preservation and those that need to be fixed. These hearings have attempted to generate a common understanding of the complex, but pressing, dilemma we find ourselves in as a state. And understanding these factors will better prepare the Commonwealth to evaluate and develop reforms that have the potential to contain cost growth and improve quality. But the point of this afternoon session, with all the data regarding challenges and unsustainable cost growth, is to turn to solutions. Every panel discussion to date danced around the issue of the proper balance

between government regulation and intervention and market innovation and progress, but if we're ever to determine a course forward, we also need to address this issue publicly, candidly, and thoughtfully and so it's with that hope that I invite Doctor Paul Ginsburg, President of the Center for Studying Health System Change to speak. Thank you, Doctor Ginsburg. (clapping)

Paul Ginsburg

Thanks. It's really a pleasure to be here, particularly on this topic, which is very engaging to me. I've been part of these discussions for a long time, and let me just get right into what I want to say. This is the history that, you know, in this country, for at least 30 or 40 years, we've been having very rigorous debates about health care, particularly how to control costs, as to whether we should use the market or government or regulation. And the reality, I'm afraid to say, is that we haven't really pursued either in a very effective way. I'll give you two examples. Actually, employers in the 1990s pursued managed care, certainly a market approach, in a fairly vigorous way, but that generated a backlash and basically their own employees and government started constraining them, don't use that tool so much. You know, on the regulatory side, think of

Certificate of Need. Have you ever seen a research study that concluded that Certificate of Need has saved money? I haven't. It does certainly have an effect and maybe some of the effects are positive, but it's not a cost containment tool in this country. What's different now? Well, health spending is much larger in relation to income, so there's a lot more urgency about dealing with the cost problem, and we're in a position now where fewer people can afford health insurance without assistance from governments. And between having to provide assistance to more people and the cost per existing enrollee in government programs going up faster than income or revenues, you know, this is a severe fiscal problem for governments at both state and federal level. Now what I want to have you take away from this is the fact that market forces and regulations are heavily intertwined. You know, debates about which one should we do, they're very sterile to me because most approaches are going to use elements of both. I mean, one thing is we know that there are regulatory frameworks that can underpin market forces and the regulations can either propel the market forces forward, make them more acceptable to the public, or constrain them so much that they fail. When you look at regulation, there's a trend towards using more in the way of incentives as opposed to a lot of detailed rules for how someone should do something. So in a sense, regulators over time, have actually

been embracing market approaches within their sphere. And you know, in recent years, a new field of economics called behavioral economics, which has gotten a lot of attention, has actually pointed the way in which regulation in some areas can actually lead to market forces working better or more vigorously and an example that, you know, as you've seen in Massachusetts recently, was when the General Insurance Commission gave an incentive for its employees to reenroll in their health plan, getting them to really take a look at what the options are and many, virtually all, took them up on the incentives and a significant proportion actually changed plan in the process. So I'm going to talk first about cost containment tools that are mostly with market/regulatory -- OK, I think these are all the tools. Basically, I'm going to talk about insurance benefit design, which has been a big issue in Massachusetts -- both a degree of patient cost sharing, and particularly incentives to choose lower cost providers. And I'm going to talk about price transparency, and I'm going to talk about provider payment reform and in a sense, you've heard about a lot of reforms. What they have in common is that they all de-emphasize the use of fee-for-service payment. That's the goal in payment reform. I don't think anyone is after defending fee-for-service. It's really a matter of what to replace it with. And one thing I'm not going to cover here is -- oh, actually I am going to cover

the level of provider prices, but I'm not going to be getting into insurance regulatory or market issues, although people on the panel will be. OK, there is a need, if we're going to address cause, to engage consumers in cost containment, and we know that cost sharing leads to lower spending and there's very strong trends towards increased cost sharing and private insurance, but zero in Medicare, and this is something that may emerge out of debt reduction talks going on and off in Washington and eventually I think we'll get there. Regulation, in a sense, has limited the degree of the use of this tool, often not intentionally. I think the biggest thing is the tax treatment of employer based health insurance, you know, because the federal government and the state governments that have income taxes, basically here have excluded employer contributions to health benefits from taxation. They, in a sense, are subsidizing the purchase of highly comprehensive health insurance. So in a sense, because they're subsidizing the premiums, they're not subsidizing the cost sharing unless you're in a health savings account. Another area where regulation has limited it is state mandates on what services to cover, and state mandates, it's known, are usually done at the behest of particular professional groups, who want to make sure that their services will be covered by insurance. Now health reform is going to require -- and I'm talking about the health

reform -- an increased government role in benefit design. Basically, if you're going to subsidize insurance, as you've come through in Massachusetts, you need to define what are the insurance products to subsidize and/or to mandate. And many people are very uneasy about the process that the federal government is going to go through soon on defining essential benefits because of the enormous implications for the overall costliness of the federal health reform. I think it's likely over time that budget constraints will lead to more conservative decisions on benefits, but if they are too expansive in getting started, it'll make the budget implications of the federal reform that much more problematic. I think there are real opportunities today to focus on provider choice, and essentially one thing that many people don't know is that high deductible plans do very little to provide incentives for choosing more efficient or lower cost providers. And the reason is that the people that are spending most of the money, when they exceed their deductible or exceed their out of pocket maximum, it doesn't matter. They pay the same regardless, but I think choice incentives can be added. Now I think the key designs going forward that are going to affect the most people are going to be tiered networks and narrow networks -- plans that either have incentives, where the patient or consumer pays less by using provider A versus provider B, or designs where there

actually are fewer providers in the network. This is a throwback to the 1990s, where more limited networks used to be the norm in health insurance before the backlash against managed care occurred. I predict that long-term that tiered designs are going to be more important than limited network designs and I'm saying this because I think people are much more willing to have an incentive to affect their choice of provider than to commit themselves at the beginning of a year, that no I won't be able to go to these providers and that was the experience with drug benefit designs, that rather than go to closed formularies, which would only have limited numbers of brand name drugs in the formulary, most insurers went to tiered designs, where there were three, or now four or five tiers, where you can still get coverage for any drug that you use, but you would pay more for going to the non-preferred tier. There has been a recent increase in take up of these tools. The General Insurance Commission has been a leader nationwide in this and what we are seeing in our site visit work is small employers all of a sudden are becoming much more interested particularly in limited network products. Now, I believe that these designs, whether limited network or tiered designs, are going to become more powerful over time, as our technical ability to make judgments as to which providers are really less expensive and also to bring quality into the equation. So we will have better

assessments on the relative costliness of different providers, better data on quality, and I think the better data on quality may lead to consumers being more willing to choose a low cost provider. And one thing I see happening is really a byproduct of the Affordable Care Act, is that many of the tools, such a grouper, that are going to be developed by the Medicare program, to implement things like, you know, its value based purchasing, for hospitals and physicians, are going to be very valuable to private insurers, who have been under fire from providers, saying that well, your tools aren't good enough. You know, we're really much better than you think or we're less expensive than you think and in a sense, I expect that once the Medicare tools have been developed with input from providers, that private insurers will use them and their tiered network designs will be much more acceptable to providers than has been the case so far. Now let me talk about designs, oh and market forces. How will these designs save money? There are two ways. First, some patients will go to a less expensive provider, and that'll be a savings, but I think the real savings will be when the higher providers perceiving that their loss of patients will decide, hey we need to get our act together. We need to get our costs down. Otherwise, we're going to lose out in this competitive marketplace, a marketplace that's been made more competitive by the presence of the tiered designs into it. And

I think that the savings from provider responses potentially will be much larger than the savings from people shifting from one provider to another. Now, there are some serious barriers to tiered networks. You know, some hospitals have refused to contract, saying well I won't contract with you unless you put me in the preferred tier. There are some areas where there's not really no effective choice. There's only one system or at least for some services. And government can take action to support tiered designs, and Massachusetts has taken the lead and legislation last year to prohibit some of these contracting practices, but a concern I have is that often, when government takes steps to encourage tiered designs or limited networks, they will attempt to regulate network adequacy and it's important to do this carefully. Yes, network adequacy is an issue, but in California, the Department of Managed Health Care, which regulates HMOs and most Blue PPOs, has truly undermined the leverage of the payers because basically, the way their rule works, is that if a hospital, you know, doubles its price and the insurer wants to drop it from the network, they have to go through a yearlong process to get permission to do that. During that year, they are paying bill charges. So in a sense, insurers in HMOs almost don't have the ability to remove a provider from the network. So if you're going to regulate network adequacy, you need to do it very carefully. I would

advise against trying to regulate analytic techniques of saying, well here's how you have to do your comparisons plans to determine who should be in the preferred tier. I really see that the analytic techniques are developing rapidly and I think insurers have sufficient incentives to do it well. Now, I have some comments on price transparency because I hear so much about it and you know, this reflects on -- and what I'm going to say about price transparency is that most of it is not useful. It has to focus on what a consumer or a patient pays by using different providers and irrelevant price information has downsides. You know, it can spur higher prices and concentrated markets and it can lead to frustration. For insured services, it's the benefit structure that matters, and you know, such as the information in tiers, as to you will pay 500 dollars to go to this hospital, 1000 dollars to go to that hospital -- that's what's meaningful to patients. Insurers are the most likely source of what I would call the actionable information. The one exception is benefit designs that use co-insurance, where the consumer pays 25%, but I think tiered designs are much more powerful that co-insurance designs. Now, one thing I will say is that transparency on prices, such is the data that the Attorney General and the Division of Health Care Finance and Policy has put out, they are very useful for policymaking, in a sense to get people to focus on what the issues are, so they can

make policy, but we need to distinguish between what's useful to get out to the public, as the context for policymaking and just throwing a lot of numbers at people that they have no way of acting on because of the potential for negatives from that. OK, provider payment reform. I mentioned the broad consensus that we can really gain efficiency and quality by getting away from fee-for-service. The problem is we don't have anything right on the shelf now that is all ready for implementation, except for some stakeholders opposition. And we're really beginning a period of development and experimentation. We've seen some innovative and private insurer contracting with providers, in a sense are blending elements of capitation and fee-for-service and the alternative quality contract that is used by BlueCross BlueShield in Massachusetts is an example. There are many ACO contracts being negotiated in different parts of the country with private insurers. They're not waiting for Medicare. Another innovative that is contracting strategy is bundled payments around a hospital episode, and you know, we're seeing a fair amount of that. Now the Affordable Care Act authorizes in funds many Medicare initiatives and we're seeing Medicaid programs taking the lead, especially in medical home initiatives. Many of these innovations are entirely compatible with each other. For example, you can have medical home payment, you can have episode bundles, and it could all be

within the umbrella of a blend between capitation and fee-for-service, such as an ACO. So as far as choosing between innovations, it's not really a matter of any of them being inherently contradictory or inconsistent. It's really a matter of you know, the limited resources, to actually move these innovations forward. I think a key thing in provider payment reform is coordinating among payers and it's really a challenge to providers when the payers aren't coordinating because they could pursue very successfully, increasing their efficiency, but if too small a portion of their payments is on a capitated basis, and most of it is fee-for-service, they could really lose out. So when I talk about coordination speeding the transition, there are two sides of the coins. It's higher motivation for providers, if more of their patients will be under innovative payment systems, and it's also protection for them, so that if they actually succeed in making things more efficient, they won't be penalized by a large proportion about fee-for-service payment. Now the question is timing. When is it time to come together on payment methods? You know, is it now? Is it in a couple of years? And if we come together on payment mechanisms, is there room? Can we leave room for further innovation when technology marches on and we have better ways of doing this? And of course, Massachusetts has really been the pioneer at thinking through about coordinating what different payers are

doing. So certainly, government can do this. Government can actually convene private payers and that's useful. You know, if you think of the Integrated Health Care Association in California, which I don't think government was involved, but basically the plans and the providers got together with a lot of anti-trust lawyers telling them how to do it, so they don't get in trouble, to agree on what would be the metrics for pay for performance, not what the pay for performance schedule should be, but simply you know, the measures and I think that's been seen as fairly successful. So certainly, government can specify methods that all should use, or they can certainly help convene the private payers so at least they can coordinate around some methods. Let me say some things about provider rate setting. Of course, Massachusetts had hospital rate setting. The experience nationally in the 1970s was varying degrees of accomplishment on cost containment. There were various reasons that I won't go into that it was abandoned in many states, but not all, in the 1980s and 1990s. It's really worth paying attention to the Maryland system, which you know, stayed the course, seems to have been very effective in reducing cost per admission over time and still staying politically viable. Now there are a few design issues that I want to go over in rate setting, should Massachusetts decide to take that route in the future. One big question is whether this should be limited to

private payers only because frankly, it's challenging to include Medicare and Medicaid in them, particularly Medicaid, because particularly if they choose a governance structure such as an independent commission or authority like Maryland has, in a sense, that means delegating control over a large element of Medicaid spending to an independent agency. Also, with Medicaid payment rates being so low now, you know, there needs a grandfather, a significant differential between Medicaid rates and rates paid by other payers. It's going to be a problem to deal with the wide variation in private payer rates that the reports you have in front of you have demonstrated in this state, and I'm sure that's the state in every other state. It's certainly what I've shown in my national study on variation payment rates and this means there will be a need for a lengthy transition. You can't put them all on the same payment schedule at once, but I think there are opportunities to in a sense have the higher priced providers get lower increase. Over time, this will move much closer to a uniform system. State rate setting actually has an opportunity to lead in payment reform and this might require, however the expansion of scope beyond hospitals, because many of our payment reforms -- bundled payments, ACOs, go much more broadly than hospitals. They all include physicians. Many include other facilities, so I think that's a challenge. As far as the ability to lead on payment reform, if

you look at the state of Maryland, in recent years, they have been consistently ahead of the Medicare program, as far as their payment system. You know, they fixed up their DRG model a few years earlier. They have a much more impressive approach to readmissions than the Medicare program does. And if Maryland or West Virginia, the only rate-setting states I'm aware of now, are seen as representative of the future, both of them appear to have carefully guarded -- I don't mean guarded -- carefully stayed out of the way when private insurers and providers have gotten together on innovative payment methods. They basically have had -- they've had very basic review and have, you know, I think let most go forward, if not all. So actually, I've got a few conclusions which I should have put in my slide for my summary, so my apologies for not having it on the slide, but we should be pursuing both market and regulatory strategies, realizing how intertwined they can be. I think the most promising market strategy is benefit designs that incent provider choice and government can support this or they can inadvertently hinder it. I'm concerned about the enthusiasm about price transparency or in my more cynical days, sometimes I think about government showing that they're doing something without spending much more money or offending stakeholders, but the work of the Attorney General and this Division has been extremely valuable for policymaking in this state, as been

influencing policy thinking throughout the country. Provider payment reform I think is a key towards going forward in containing costs, and the real challenge is going to be coordinating this across payers. At this point, what I envision for rate setting, is a stick in the closet. Should market approaches not succeed in addressing price issues, I think that stick may come out in a few years. Thank you very much. (clapping) I'd be glad to take questions. We've got time. I'm going to depend on your program to introduce the panelists, if you don't mind, but oh OK. So we're going to hear -- is this the order? OK, so in order, we're going to hear from Jeffrey Selberg, who's Executive Vice President and Chief Operating Officer of the Institute for Healthcare Improvement. And then we're going to hear from Glen Shor, Executive Director of the Commonwealth Health Insurance Connector Authority. And then we're going to hear from Laurie Sprung, who's the Senior Vice President of the Advisory Board Company and we'll hear from Christopher Koller, Health Insurance Commissioner for the state of Rhode Island, and finally, Christine White, an Attorney of the Federal Trade Commission, Northeast Regional Office.

Jeffrey Selberg

Thank you, Paul. I'm, as Paul said, Jeff Selberg. I'm Chief Operating Officer for the Institute for Healthcare Improvement. It's a privilege to be here today to testify. We have a short amount of time, and so I thought I'd read my testimony. Much can be said and has been, with regard to the role of the market, the role of regulation, and how the two intersect to inspire the creation of greater value in health and health care. With the five to ten minutes I have, I felt it best to narrow my comments to five key points that were made in the report: Examination of Health Care Cost Trends and Cost Drivers by the Office of the Attorney General, which was made public on June 22nd. I am going to quote from the report and then provide our perspective. First quote, "Market dysfunction has resulted in threatening the viability of the more efficient providers."

We agree that the market should reward providers who advance the health of the population, improve the experience of care and effectively manage per capita costs. We at IHI call this the Triple Aim. These will be the providers who have innovated with a specific focus on care coordination and care transitions and will show measurable results in safe, efficient, effective, equitable, timely and patient centered care -- the six aims of the Institutes of Medicine. This should result in the higher performing providers thriving and the lesser performing

providers feeling that they have no other choice but to learn and adapt to improve their results. Two, to quote, "To control cost growth, we must shift how we purchase health care to align payments with value, measured by those factors the market should reward, such as better quality." We agree. This will require much greater transparency in the marketplace such that more informed decisions can be made by the public, patients, providers, payers, purchasers both public and private, and the community at large. This will require advances in how data is converted to usable information, where the definition of quality includes clinical, financial, service, and satisfaction measures. It also means changes in culture where information is used for learning and innovation as opposed to judgment. This will require an ongoing process in the development of all payer and clinical data bases that can be accessed by providers and public alike. Three, quote, "We must give consumers increased options and incentives to make value based purchasing decisions through tiered and limited network products that, without penalizing necessary and appropriate use of health care, make consumers more responsible for the differences in cost when they elect a more expensive provider." There are several points to make here. First, comparative cost is a critical factor and it must be balanced by what is produced for that cost. Therefore, as stated above, Health Plans and the public must have access to

both quality and cost measures to make an informed decision. Two, the goal is the right level of care in the right place at the right time. The result of any market based or regulatory approach should be to inspire those in health and health care to innovate and improve what they do first and foremost for the patients, public, and communities they serve. Without innovation driven by the passion to create greater value on behalf of those we serve, we will remain where we are. IHI believes that creating greater value is driven by innovation through appreciation for systems, understanding variation in practice, learning through small tests to determine if changes result in improvement, and being sensitive to human psychology in a change environment. Three, the critical factor to "make patients more responsible" is to develop relationships that are built on mutual trust and respect. This will require that our approaches -- systems of care if you will, are designed with the patient involved, not just with the patient in mind. Without this level of involvement, it is questionable whether the patient will become more responsible, but rather more cynical that the care processes are designed for everyone but them. And fourthly and lastly, transparency is a critical factor, but not just for comparable costs, but especially for the other five aims: safe, effective, equitable, patient centered, and timely. Fourth point, quote, "We recommend a competitive based approach

balanced with limited government intervention to foster effective market function." Perhaps the better terms are “targeted intervention to foster effective health care for the improvement of health.” With this, we agree with the caveats described above. The concern is timing. Will our concerns about costs overwhelm our ability to innovate and improve? Development of improvement capacity must accelerate within the field to avoid short term approaches to reduce costs that will be detrimental to our ability to innovate and create greater value long term. And the fifth and last point made by the report, quote, "Product design should reward patients with lower rates when they enroll in plans that allow for care coordination. Efforts to move the system toward payment reform depend on better engaging consumers in health care designed around primary care.” It is important to emphasize that the design of care must occur across organizations as well as within organizations with sensitivity to diversity and with the goal of eliminating disparities in care. We agree with that primary care should be more effectively supported, such that primary care providers can be more effective care coordinators. We also believe that additional innovations that build greater patient literacy and fluency in prevention and disease processes which will lead to greater levels of self care management should be supported as well. We believe that with this level of support

and with the proper application of technology, the patient can be become the true innovator in health care. And lastly, overlaying this is the need for enlightened policies in public health that will improve the environment and foster healthier lifestyles. Thank you for the opportunity today.

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Thank you Jeff. Glen?

Glen Shor

Great, thank you. Thank you. My name is Glen Shor. I am the Executive Director of the state's Health Connector, the Commonwealth Health Insurance Connector Authority. I appreciate the opportunity to testify today and in my testimony, I'm going to focus on two different types of public interventions in the health insurance marketplace, by the Health Connector, which are

designed to expand access to affordable health insurance. The first intervention is embodied by our state subsidized Commonwealth Care program. Commonwealth Care offers state-subsidized health insurance coverage to people -- adults in the Commonwealth, up to three times the poverty level, who don't have access to employer-sponsored health insurance. It imposes progressively increasing monthly enrollee premiums for those over the poverty level, though public dollars pay for 90% of the coverage costs for the program. Commonwealth Care currently has 160,000 enrollees plus there are an additional 18,000 enrollees in the sister Commonwealth Care Bridge program, which is a state-subsidized health insurance program for a subset of legal immigrants. Together, these programs cover about 178,000-180,000 people, which is about 45% of the newly insured in the Commonwealth since 2006. Commonwealth Care is effectively the exclusive distribution channel for coverage for this population and it is indeed a population of considerable scale and given that and given the Connector's in-house expertise about running health insurance programs, you know, this positions us to negotiate the price for coverage of this population with health plans, which we do through highly public and highly competitive procurements on an annual basis. Our approach to these procurements has been to reward health insurers for pushing the envelope of innovation to offer to lower cost high quality

coverage and the principal tool we've employed is tying membership to aggressive bidding, and that's something that's happened in a more and more pronounced way over the life of the program. For example, for those who pay premiums, who are required to pay premiums for Commonwealth Care coverage, their premiums are aligned with the costs of the health plan they choose. For some members who don't pay premiums, we are by stature in some instances precluded from charging premiums with some members, for that subset of the population, for very new members to our program, we are now at a point where we are assigning them to a choice of two health plans that represent the lowest bidders in our program. That is, among other things, because we don't have other tools to incent health plan aggressive bidding, with respect to this population, and also because that's focusing on assignment for a population that, for which assignment poses the least concerns about continuity of care distribution. Again, it is new members to our program. While we do this, we recognize that we have to impose safeguards to ensure that this yields the right type of competition and produces the right results for members. For example, our bidding processes are constrained in important ways. We enforce an actually sound rate range. We do not take bids below this rate range, so as to preclude predatory bidding. We use a risk adjustment mechanism to ensure that cost savings are based on

strong contracting and care management techniques and not risk selection techniques. We impose access standards, but we do take care in setting our access standards, to on the one hand, balance protecting members, but on the other hand, not precluding competition and innovation. And throughout the course of the year, we exercise stringent oversight on care delivered for members. Health plans are paid on a capitated basis. In return, we have to make sure that they deliver the care required and promised to members. The overall result of these various procurement mechanisms and levers has been that annual Commonwealth Care premium trend has been -- average annual Commonwealth Care premium trend has been about 3%. That's lower than what you see obviously in the larger market, and I think it has increasingly been driven by the emergence of innovative coverage models, very much, I think, in response to our program's willingness to reward risk taking by health plans. This model, for example, encouraged the first new health insurer entrance in the Commonwealth in years, which in turn has operated a highly visible limited network, a considerably lower cost to the state, and in turn through competitive pressures, that has spawned the recent creation of another narrower network in our program. In fiscal '12, the upcoming fiscal year that will start I think tomorrow, four out of five Commonwealth Care health plans, including these two narrower networks, bid rates

for fiscal '12 that were at or below the previous year's rates. One plan, the one that recently created a narrow network, reduced its capitation by 15%, in part by narrowing its network, by re-contracting with the leverage that comes from increased volume in our program and building on its existing care management strengths. By July 1st, tomorrow, we anticipate about one-third of our members, CommCare members, will be in narrower networks, with price points about 13-19% lower than broader network plans. Writ large, these procurement dynamics will produce about $80 million of savings in our Commonwealth Care program, which will allow us to maintain existing benefit levels, allow us to accommodate additional enrollment expected in this year, even within the confines of a level-funded budget. I am, and we are at the Connector, mindful of the fact that -- and this is just a quote that rings in my head: “With great power comes great responsibility” -- anybody know where that comes from? There you go. All right. Uncle Ben, a very wise man. That’s correct. You know, again, I mentioned the fact that we impose access standards to ensure that narrower networks don’t go below a certain point. In launching this experiment with limited networks, we first consulted survey data, where we looked to see what was the experience of some members already in narrower networks, so that if we were to scale them up, did we have concern that by definition, it would result in inadequate

access to coverage and care? We, you know, we will continue to enhance our oversight during the course of the year to ensure that this works and you know, we are also very knowledgeable about the fact that the innovations in the Commonwealth Care program occur amidst innovations across state health insurance programs. The GIC was mentioned earlier as a pioneer on the issue of tiered networks and has also made considerable headway with moving members towards limited networks and saving a lot of money for the Commonwealth and again, adding breadth and depth to that model so we can learn from it. The state's Executive Office of Health and Human Services has recently launched something known as a patient centered medical home initiative, focused on having Commonwealth Care, Mass Health, Group Insurance Commission, commercial health carriers work with 45 or 46 practices across the state -- compensating primary care appropriately to ensure care coordination and achieve savings through avoiding unnecessary hospital and emergency department visits and we anticipate a program like Commonwealth Care will work with other state health insurance programs over the years to come to fulfill the governor's charge of having state health insurance programs help, though not exclusively, drive payment and delivery system reform in the Commonwealth. I would love to talk more about our Commonwealth choice program in comparison,

but I think I’m at stop point, so maybe somebody will give me that as a question. Thank you.

Laurie Sprung

Hi, I’m Laurie Sprung from the Advisory Board Company in Washington, DC and thank you for giving me the opportunity to come and talk to this group. In our work, we have the opportunity to work with dozens and dozens of the organizations around the country of the provider organizations that are taking decisive steps to organize around lowering costs and providing greater value, and from that work and from that perspective, I thought that there were three things that I would use my time to share with the group today. First of all, I wanted to share with you some of the challenges that those providers face in trying to organize around value and in trying to drive down the cost of care. From that, I want to talk about the emergent models that we’re seeing that can really impact the cost of care and really what the common principles underneath those are. What are the common activating elements that we see really driving to meaningful improvement in the cost of care and from

that then really to go to where we see the most [impactable 45:06] role for the markets and government, in terms of stimulating that kind of activity. As has already been noted, when you talk to providers, there is absolutely widespread acceptance of the need to reconfigure the delivery system to better manage cost and better gain efficiencies. The challenge is that very reform is at odds with the current financial incentives of reimbursement for most providers. So financial success today is based on the growth and maintenance of volume. We're trying to switch to value, but there's several challenges along that migration path that providers face. First of all, as has been noted, is the uncertainty. There's nothing on the shelf yet around this, so both in terms of what the endgame is going to be in terms of payment methodology, as well as what the timing of that -- health care executives are challenged to act today. The second piece, I think, is around the lack of consensus around the types of payment models that are going to be -- there's no critical mass around specific innovations. Different payers incent different things, even when there is contracting around performance. And then finally, there's a multi-million dollar investment that needs to be made in terms of building the infrastructure to better coordinate care, capital dollars, physician time, many of those physicians being independent of the hospital's staff time as well. The business

value proposition for health care executives is a challenging one, even though they look to say, it's the right thing to do. The emergent models that we've seen successful in really driving to better cost performance, keep that fee-for-service financial success today under existing reimbursement models front and center, in terms of helping navigate a transition to a more value-based system. And I think the principles around that is really where I think the role of the market and the government sort of comes from. Quickly, the models that we've seen that really do have the greatest potential in terms of reducing costs and improving quality are hospital-sponsored clinical integration, the formation of networks across the continuum to work together collaboratively to drive to the kinds of improvements that we've been talking about across these days of testimony, as well as what I would call large scale multi-stakeholder involved demonstration projects around primary care, prevention, chronic disease management, often through the medical home model. Four things that I would point out as the common principles underlying those two kinds of emergent models -- the first of them is the engagement of providers across the continuum, so you know, physicians and hospitals -- the challenge with that being that frequently, those are independent economic entities, so the second piece then is the inclusion of a model for diminishing anti-trust concerns, so that those

independent economic entities can collaborate. Third is the integration of new technologies, both to drive coordination, and we've talked some about electronic medical records and so forth, but beyond that, it is also the analytics that are needed to drive real performance improvement. And I think the fourth piece, and really going into what can the government and the markets do differently, is around what activates this, and what activates this is the engagement of payers and actually even more often, employers who are filling to pay to fund that transition into a more accountable era, into a more value-based piece of it. And it is frequently the employers who are acting first, who are pushing the payers to really negotiate on the basis of value versus volume. When I think about getting to critical mass, how do we really, sort of, make consistent incentives? I think there's a very meaningful role for the government, for state government, in terms of creating critical mass, in terms of differentially contracting in its role as an employer, with those provider networks who are organized for value. So when I think about state employees, retirees, Medicaid beneficiaries, there is a very large number of beneficiaries for whom the state is at risk for the cost of care and where they can direct those funds and direct those patients towards provider organizations, with the incentives to really better manage the cost of care. The second piece that I would

bring, just to the table just in the interest of time, is in these multi-stakeholder arrangements, there is an arbitration role that makes sense. The different stakeholders, there's a dividing up of those savings. There's community benefit, there's reduced medical loss ratios, there's payment to physicians to providers -- it's got to be fair and we've seen very successful roles for the state, in terms of making those discussions and making those negotiations fair. I'll stop here. Thank you.

Christopher Koller

So I'll continue. Thank you very much and I appreciate the presentations of Doctor Ginsburg and the panelists who have preceded me. As is said before, my name is Chris Koller. I'm the Health Insurance Commissioner of Rhode Island. I'm going to speak from this experience, where I've worked for the last six years and particularly from the perspective of aggressive comprehensive commercial insurance rate review. It might be instructive for some of the issues that have been addressed in these hearings. I'm going to focus on four components -- what we've done with rate review in our state, how we've attempted to

use that to change the delivery system, some of the things that we've learned, and what the implications are going forward. First, what we've done -- in Rhode Island, the Health Insurance Commissioner has authority to review and approve rates for all lines of commercial insurance, individual small group and large. In doing so, the standards to be used statutorily include affordability, so affordability is to be balanced against solvency, consumer protection, and fair treatment of providers. In Rhode Island, what we have done is to use this authority to review not the rates to be charged for individual products, but the overall rate factors to be used by health plans to calculate their individual subscriber premiums. Rate factors consist of administrative costs, projected profits, and projected medical expense trends, both utilization and price. By focusing on rate factors, not product prices, we can keep the attention on the system performance and on system cost drivers. The review process works over a two-month period every year. We collect and review this information from all carriers in Rhode Island. We put them on our website, we analyze it, we post it all for folks to see, we collect public comment. At the end of the period, we can accept, modify, or reject a proposed rate factor and the insurance company can either accept our decision or appeal it into an administrative hearing. We're actually at the end of that process right now. As a result of this, what we

have is greater transparency in public education around the cost driver's premiums and greater health plan accountability. We can outline differences in expense trends by carrier, by expense component much like the work that [Dictive? 52:50] does and identify differences between price and utilization. We can also compare our performance to regional and national benchmarks. The bottom line's been mixed. The public is much more attuned to cost drivers. The offices requested premium increases significantly by multiple points, to the point where two of our three commercial carriers are now losing money, but the resulting premium in expense trends have not been appreciably different from the region. Because of this and a weak economy, actually the number of our commercial insured in Rhode Island has diminished by 10% over the last five years, a cause of great concern. As a result of this, we've put a much clearer focus on the role of medical expense trends in driving increases and the incentives, as we've talked about, to create those trends. We have authoritative data, just has been produced in Massachusetts about variations in hospital payments depending on the size of the inpatient payments. We haven't looked at outpatient, depending on the size and system characteristics of the hospital that's getting paid. We think it's almost from 80% of Medicare to 160% of Medicare, depending on what institution you have for medical surgical inpatient services. So our Consumer Advisory

Council that works with our office, in 2008, identified four systemic affordability priorities that we want insurers to focus on going forward as a condition of gaining approval for their rate factors. The intent was to align carrier action around the systemic delivery system changes needed to improve affordability. And the four standards that resulted were to increase and strengthen the primary care infrastructure in the state by increasing the portion of medical spend that goes to primary care by percentage point each year, from about 7% of the total medical spent to 12% by the time we get done with this. To participate actively in our all payer patient centered medical home, which has now been up for five years, that initiative, to pay for the adoption for electronic health records and to stimulate hospital payment reform. My office oversees the administration of and compliance with these standards. We're trying to provide a framework that'll allow for innovation within it and then monitor the results and hold health plans accountable. We did not see much progress in hospital payment reform, so therefore last year, we articulated six specific standards that we wanted health plans to execute in their new contracts with health plans. Movement of units of payments towards DRGs or something more innovative, use of Medicare CPI for price inflators, adoption of quality incentives with the ability to earn extra money beyond the Medicare CPI,

common standards for care coordination, common practices or projects, if you will, for administrative simplification, and then public release of these terms because we think that accountability is important. The health plans are complying completely with the first three affordability standards. For the hospital conditions, they've only been in place for a year. We're monitoring their compliance right now. I'll give you a little bit of a preview. Looks like they all get partial credit. They're getting there, but no surprise, they haven't lived up to all the standards completely. So my third point is what we've learned as a result of this, and this will sound a lot like what we've heard before. Insurance rate review is necessary, but not sufficient, for an affordable health care system. It creates transparency, accountability, and if we do it right, a system focus, but it does not reduce the cost drivers inherent in the medical system. Second, the private contracting model does not work for health care providers and insurers, particularly where one or the other has market power. It produces price disparities, a lack of accountability, cost shifting, and a lack of innovation. We need more publicly accountable methods for overseeing payment reform. It could be as far as what Doctor Ginsburg talked about it, with all payer rate setting, or some other degree of public accountability and oversight, exactly the things that you are wrestling with in

Massachusetts. Third, alignment of payers is absolutely essential for delivery system reform. You've heard it from both the public and the private side today. This alignment is really important, so long as providers see multiple payers who pay in different and inconsistent fashions. We've been able to prove that you can change this with primary care, with our work in the all payer medical home, and also with our investment in primary care, and health plans are willing to go along with that. So long as they know what the rules are, they know that no one is going to be able to cheat or cut corners, and they have a public official who can be the bad guy and can convene them to address anti-trust concerns. Fourth, and perhaps most importantly, what we're really driving at here is culture change in communities. Doctor Ginsburg's work and subsequent work by Atul Gawande and Mark McClellan identify the low-cost medical communities. It's not driven by whether they have for-profit insurers, how many hospitals they have, or how many MRIs they have. It's driven by some of the things that Doctor Sprung talked about -- engaged leaderships by employers, engaged position leadership, communities that are absolutely fanatical about measuring and improving population health and population quality, the things we hear about from IHI. The best way to reduce costs in medical care is to stay healthy. That can only be done in community and must be led by individuals and institutions, not left to

markets. Finally, one of the implications for our collective work in reducing health care costs, like Doctor Ginsburg, I'd say that the work of markets and governments -- neither of us have a sterling record of success here. I think the future has to involve consumers more directly. We can learn from markets, where there've been a number of conversations about this so far, but for non-acute services, the people who receive care must be involved in treatment decisions. We have examples of that with how pharmacy benefits are constructed. Doctor Ginsburg held up some ideas with value-based benefit design. I think consumers have to be involved in the purchase of insurance. Part of the reason why the Connector has been so successful in the way that Glen Shor talked about, is because individuals are making individual purchase decisions. They decide on different bases rather than employers. But even if you have individuals more engaged in purchasing the parts of medical care that are commodities, a whole bunch of consumers empowered by smart phones and smart benefits are not going to be able to invest in public health, accomplish provider payment reform, improve care coordination when they're ill, define the central health benefits and resource constraints, revitalize primary care, or curb institutional power and self interest. Those are public functions that affect the common good. They are essential to

our goal of improved system performance and government should not shirk from those responsibilities. Thanks.

Christine White

OK thanks. Now it's my job to start to make the case for why health care should remain a market-based industry, at least in part. I'm not going to use my slides because I'm going to try and shorten my remarks a little bit, both to keep the program on track and to save my voice, which I have to apologize for. My name is Chris White. I'm a health care Antitrust Attorney with the Federal Trade Commission -- excuse me -- and it's Northeast Regional Office, which is based in New York. I'd like to thank everybody for the opportunity to participate in this public hearing and I need to expressly state for the audience that materials I submitted, my statements here today, are entirely my own, and they may or may not reflect the views of the Federal Trade Commission or any individual commissioner. With that background, I want to jump right into describing for you what the FTC is for those of you who are not familiar with it, and underscoring the importance of its consumer protection and competition mission in the health care environment in particular. The Federal Trade Commission is an independent

agency that is charged with preventing unfair competition and unfair or deceptive commercial acts or practices. The agency has a very broad enforcement jurisdiction, which covers a number of markets and industries. Its very creation and its ongoing result from a strong and abiding bipartisan consensus that market-based competition achieves the most socially desirable allocation of resources, the lowest prices, and the highest quality for products and services. Because the agency obviously has a finite budget, the FTC tries to invest in industries and enforcement actions that will most benefit the greatest number of consumers, and of course, due to the size and significance of health care, this industry has long been and remains a key focus of the agency. The Federal Trade Commission has an important role to play, working with collaboration with the United States Department of Justice of Antitrust Division, but also with the state Attorney Generals, who are also active in health care antitrust consumer protection enforcement. So the purpose of the antitrust law is to prevent private business agreements and practices that unreasonably restrain competition. Doctor Ginsburg and some of the panelists have alluded to some ongoing debate about the role of competition in the health care industry, and at times, I think this debate has been somewhat complicated, because health care providers often don’t think of themselves as competitors, and they tend to vocally resist any

notion that they compete or engage in rivalry with one another. But as a matter of economics, providers who offer common services generally are viewed as reasonable substitutes for one another, at least from the perspective of the consumers who are seeking their services. And it's fairly well documented at this point that health care providers, like health plans, respond to financial and competitive incentives -- competitive incentives including, in some cases, through collaborative measures, I might want to add, provide incentives to innovate in terms of developing new products, new services, better pricing, and enhanced quality initiatives. It also has been said that the health care markets are imperfect, or they have certain unique characteristics, but in our experience enforcing antitrust laws in the health care industry over several decades, I think we've demonstrated that the antitrust legal framework is sufficiently flexible to recognize and accommodate those special characteristics. But I also want to note that antitrust is not predicated on an assumption that the market, if left entirely on its own, will cure all problems. So to be clear about the role of antitrust enforcement, I wanted to specify that antitrust enforcement is intended to protect competitive processes. Effective enforcement is intended to prevent or stop anticompetitive agreements that increase prices above competitive levels, which correspond to lower levels of output

and less consumptions, which of course is a particular concern in health care, where we want our patients to get good care in a timely fashion. Effective enforcement can also eliminate market barriers and spur innovation that improves care, expands access, and promotes lower costs. What I also want to be clear about is that antitrust does not pick winners and losers, in terms of particular providers, products, services, or business models. In a competitive marketplace, providers and health plans have incentives and significant latitude under the antitrust laws to develop and implement new products and services, as well as novel financing in delivery arrangements, without raising antitrust concerns. In fact, many of our enforcement actions are intended to prevent providers from blocking new innovations and new models. The goal of course is that in a competitive marketplace, consumers have the ability to make their own choices about the health care products and services they prefer at competitive pricing. I also want to note that self regulation has a very important role to play as well. Private professional associations and standard setting organizations help to promote competition when they help to ensure that we have high quality licensed and accredited entities providing services, to help ensure the competency and the quality of the providers who are in the marketplace. In some instances, they generate significant quality in comparative information. They

also may play a role in preventing deceptive advertising or other abuses that can distort the ability of market forces to reflect consumer preferences. I want to switch gears for a moment and talk very briefly about the FTC's activities overall in the health care industry. The FTC has a role to play in terms of bringing enforcement actions. We have been particularly active in recent years in trying to block pay-for-delay, where branded pharmaceutical companies seek to keep generics off the market by paying the generics to stay off the market. We obviously have a historic role in terms of merger enforcement activities, and we have a long history of bringing price-fixing and group boycott cases in the health care industry in particular. With respect to the price-fixing and the group boycott cases, I want to note that the FTC distinguishes between legitimate collaborations that are intended to achieve cost savings and promote quality on the one hand, and on the other hand collaborations that are designed to and have the effect of obstructing competition and raising prices. In terms of other non-enforcement activities, the FTC has historically been very active and continues to be active in sponsoring and participating in health care antitrust and consumer protection workshop and hearings, and has also issued a good deal of written guidance, in the forms of enforcement policy statements, competitor collaboration guidelines, merger guidelines, and a

variety of other arenas. I'm not going to provide you any more details on those areas, but I will note that our website provides very detailed information about all of these activities and it's quite easy to use, so I encourage you to look for that. The third portion of my presentation involves looking forward and anticipating health care reform and asking, is there a goal for competition and antitrust enforcement? And no surprise, my answer is yes. What I would like to do is look to what has been going on at the federal level with the Affordable Care Act, where I think we have a very good example of the extent to which regulation and antitrust can work hand in glove. The draft regulations that were issued by CMS earlier this spring to implement Section 3022 of the Affordable Care Act, explicitly recognizes the important role that competition and antitrust enforcement have to play in health care markets, even ones that are regulated. The draft regulations require, among other things, that providers who seek to participate in the shared savings programs, be antitrust compliant, and the draft regulations also seek to encourage competition between ACOs in markets that can sustain multiple ACOs. On the same day that CMS issued these draft regulations, the FTC and the Department of Justice jointly issued an ACO Antitrust Enforcement Policy statement. This further illustrates the flexibility, the applicability of antitrust enforcement working hand in glove

with the regulatory scheme. What the ACO statement does is it seeks to reduce the antitrust risk and offer greater certainty for health care providers that wish to offer ACOs, and it does this by establishing a role of reason analysis for ACOs, taking them out of the risk of being condemned as per se a novel. It creates new ACO specific safety zones, and it coordinates the antitrust review with the CMS application and review process, providing a streamlined analysis and expedited ACO review. So in conclusion, I would like to say that competition and effective antitrust enforcement does have an important role to play in health care, in terms of stimulating innovation, controlling costs, and providing alternatives for consumers, not withstanding special characteristics of the marketplace. Antitrust enforcement has long played, and until I'm told differently, will continue to play a key role in ensuring that innovations by governments and private actors are able to compete for acceptance in the marketplace. Thank you very much.

Paul Ginsburg

Well thank you to all the panelists, too, from watching the timekeeper -- looks like you all stayed on time. And --

Jody Gittell

Doctor Ginsburg, actually before you begin, I received a few questions for your presentation.

Paul Ginsburg

Oh great, OK.

Jody Gittell

If you don’t mind.

Paul Ginsburg

Sure.

Jody Gittell

And the panelists, feel free as well to chime in if you have a response. A few people inquired, how long is a reasonable period of time to allow the market approach to work before the rate setting stick needs to be used.

Paul Ginsburg

Oh, well that's a tough question. Yeah, I would say that we shouldn't be -- we should be impatience, that you know, we've been looking to the markets at work for a long time now and you know, frankly, yeah I really think that given the essence of the market approach being you know, benefit design and leverage, I think that's -- if we don't see that happening soon effectively, then I think it'll be time to really consider getting the stick out of the closet.

Jody Gittell

So earlier in the week at the prior panel sessions, we've heard about -- several panelists suggested temporarily freezing prices. What do you think would be the impact of that measure

and would that really help control price increases over the long term?

Paul Ginsburg

Yeah, well -- and I think the virtue of temporarily freezing prices is to get something done while you're then under a tight schedule working on the longer term thing. I think it should be seen as perhaps a one year transition to doing something, you know, designed for fiscal emergencies on the part of government. So I think that it's not a great policy, but sometimes it's needed. Actually, getting back to the first question, I think what the answer I should've -- you know, I think that's really up to you, as far as how much time to give the markets and it's really, you know. In some parts of the country, they're a lot more impatient with the market than other parts of the country and I think that's why I've always envisioned that rate setting approach, if it comes, will come from the states because of the ability to tailor the decision to go there to the political culture of each state. I think Massachusetts is likely to be one of the leaders in this area that goes there.

Jody Gittell

So the Division is currently working on developing an all payer claims database. Once that database is available, do you think it's beneficial for the division to develop and publish reference rates for global payment, bundle payment, and fee-for services?

Paul Ginsburg

I mean, I think when you say published reference rates, you mean beside -- well you didn't write the question, but by publishing reference rates, does that mean actually regulating prices or just publishing the rates and then letting insurers decide what is to be the reference price? Sorry I didn't get your question that well.

Jody Gittell

And one more. Is there a concern if we rely solely on hearing and provider choice, that we will have an inequitable system or

perception of inequality in that those who can afford it have the choice, but not those who are less affluent?

Paul Ginsburg

That's an excellent question. I think it's inevitable that we're going to see a pattern of you know, say, as we've seen before, that people with fewer resources will go into insurance products that are more restrictive, as far as what providers they can go to. They will be the people that perhaps respond more readily to incentives to use more efficient providers. I think the best we can do to deal with this potential for inequality is to focus on equality and to make sure that the lower price that all providers are doing a good job, or I should say a better job, than they're doing today on quality, so that the loss of choice for people with less income will not be that harmful, but I think that you know, I would not, you know, decide not to pursue these ideas for cost containment. I don't think the country has a choice to say, we're not going to pursue cost containment because it would inevitably lead to greater inequality, because the country doesn't have that luxury the way it did in the past. Are there any questions that made from people in the panel before I ask you questions? OK, I've got at

least one question for all of you and I'll ask one at a time. OK, great. I forgot about the cards. That's why I didn't ask any questions right away. Question for Jeff Selberg. You know, the Institute for Health Improvement has a sterling reputation for basically engaging hospitals, who are driven by mission, wanting to improve their quality of care to work with the Institute, work with peer hospitals to pursue improvement. When you were making your statements and responding to, I guess it was the Attorney General's report, I interpreted it as, for each or many of the points, you need to set the bar higher. You need to not only do what you're proposing to do, but make sure that there's more quality involved, et cetera, and if prompted a question, you know, are you raising the bar so high that we can't do anything? And the specific question is, how do we accelerate improvement? Do you believe that there's enough initiative, mission driven, to improve in efficiency as well as quality about as fast as we can or are either regulatory measures or market incentives needed now to go faster?

Jeffrey Selberg

Well you said you were going to ask me one question, not six. (laughter) So I'll try to cover what I think you asked me. Is

there a place for regulation and market-based initiatives to stimulate greater awareness, greater will, to improve? Absolutely. Are they needed? Based on, I think, what we believe is the level of improvement capacity and the will to innovate, yes. Are we raising the bar too high? We certainly don't think so. We think that it is about creating capacity in not only hospitals, but federally qualified health centers, group practices, health plans, whole communities, to think in terms of will ideas and execution, to think in terms of a measurement to know when a change is an improvement. We believe in a particular improvement science and we believe that really any organization can develop this capacity, and by developing it, they will become more efficient and effective and actually reduce costs through improving quality, as we define it. So we think it's all there and we think really, the role of regulation and market-based initiatives is to inspire the development of that capacity and then the execution of it.

Paul Ginsberg

Thank you. For Glen Shor, you really made a very good statement about the virtue of active purchasing and actually, in the part

of your testimony that you didn’t get to about Commonwealth choice, is there --

Glen Shor

Thank you. (laughter)

Paul Ginsberg

Can you discuss the -- I mean obviously, Commonwealth Choice because individuals are smaller groups, can stay out of it if they want. It’s probably more limited in how much it can impact the market, compared to Commonwealth Care, and the question is, you know, would it be feasible and how large is the upside of actually bringing all of the individual and small group market through Commonwealth Choice?

Glen Shor

That’s a great question. First of all, I appreciate your spotlighting just a critical difference between Commonwealth

Care and Commonwealth Choice and it's the context in which they're placed. Commonwealth Choice is not the exclusive distribution channel for small non-group coverage. People can get the same products at the same price outside Comm Choice, small businesses likewise. Comm Choice stares out at a target or an eligible population that is largely insured as opposed to uninsured, which is in the CommCare population absent the subsidy. And there's no market-wide risk adjustment mechanism. It is a fundamentally different equation, fundamentally different leverage, and obviously I think in light of that, the degree to which the Comm Choice program has actually penetrated the non-group market, probably 35,000 of its roughly 40,000 members are non-group -- shows that we're surviving based on a really strong value proposition there. It would be game changing if, you know, the entire small non-group market were to purchase group Commonwealth Choice, but it would certainly probably take legislation in the Commonwealth to do that. This is a small non-group market that's largely insured. As I said, health plans already have that population and it's distributed in different ways. There are various different distribution mechanisms already in the market, other intermediaries. Direct sales by health plans, it's the small groups in our population that are 80% served by health insurance brokers. So you know, a change to driving the entire market through that Health

Connector would be impactful, but it would not be organic. It would be a very significant shift in the distribution, and that'll surely take a revisiting of some of the fundamental equations around health reform, and I think probably legislatively would be a stretch.

Paul Ginsburg

Thank you. And Laurie Sprung, you did a very good job in talking about the need for some critical mass to come together on payment reforms because it's being difficult for providers to make the investments. And so it was clear, you seemed to be focusing on employers in particular, as having the potential to take the lead. So presumably, this is more of a local strategy. Could you elaborate?

Laurie Sprung

We've seen the impact. The reason I focus on employers is because that's where we've seen the action and the impact, right, in terms of being able to get a critical mass and a consensus within a provider organization around what are we

driving at? There's not a shortage of things for improvement, so one of the things that you see when there is not that critical mass is that the actions of one plan, and the kind of pay for performance incentives of theirs, mitigates the impact of another one because how many things can you focus on? So in terms of the state as employer, I do think that you know, health care is local, right? It is a group of physicians, a group of hospitals, a group of other providers, in a network. The policies around who we're providing, who we're working with, the principles underneath it I think can be statewide or at a federal level as well.

Paul Ginsburg

Yeah, let me finish the question. So actually, I'm going to challenge you on that because what I've seen over time is a greatly weakening ability of employers, particularly private employers, to take this initiative. Basically, for years, I was telling people, well you know about the specific business group on health. There is not an organization like them in most other communities. And the employers are for the most part withdrawn from being active in their community on these health issues. They've gone to national PPOs, mergers have meant there are --

most of the employer initiative came from large corporations with their headquarters in the town, and when you talk about state governments, you know, Massachusetts with the General Insurance Commission, and California, are the exceptions, that most state governments do very, very little. So I'm wondering whether we need to start looking to mechanisms to work to convene the insurers, rather than depending on employer initiatives.

Laurie Sprung

You know, something -- I agree with you that that would be even stronger, but what we've seen is that the impetus around it typically comes from the larger employers who are self-insured, right, who are bearing the risk for their employees and who care deeply about their own rising health benefit costs. What they're doing in turn is working with their TPAs to bring the insurance companies along with it, so sort of driving through sort of from a customer perspective, bringing the payers to the table, so to the extent that we can circumvent that process, right, to sort of bring the payers into it, I think that the provider community would be incredibly appreciative because through whatever means, it is that stimulation of innovation of

really being able to pay and share in the value that's created that's making the difference. Practically, we've seen it sort of browse through and start with employers, but if it can be at a higher level, better yet.

Paul Ginsburg

Good. OK and of course, if Chris Koller is, to be honest, the only insurance commissioner I'm aware of, is really taking steps to convene, I mean more than convene, to get the insurers on the same page, to do things. Actually, first just given your comment, just before I have the other question I have for Chris, would you want to elaborate on, say, what Massachusetts could do to convene its insurers to work towards what Laurie put out as this need for critical mass on payment reform methods?

Christopher Koller

I do that with caution because some of my colleagues from the Department of Insurance of Massachusetts are in the room. (laughter) I think in fairness to Kevin and his folks, they're working under a different mandate. The Office of the Health

Insurance Commissioner, with its staff of five or six, is actually the only health insurance commissioner in the country, is explicitly charged with focusing on affordability. So into our stature, is directing health plans towards policies that improve system access, affordability, and quality. I cannot find another insurance commissioner with that mandate, and that's a shall not a may, so I would argue that it actually starts with the legislative direction.

Paul Ginsburg

Good, I'm glad you clarified that. Other question I had is on care coordination. Your discussion of that seems to be mandating care coordination, and by its nature, can care coordination be mandated, in the sense, can you tell when it's there and when it's not there or does this really have to be wrapped into a payment reform, where coordination is one thing that organizations, if they have some capitation risk, know they have to do?

Christopher Koller

So this gets to Laurie's context or question of, not question, statement. A lot of these are contextual and local. The dynamic in Rhode Island is that based on Medicare data, we're about at the middle of readmission rates within 30 day Medicare readmission rates, but what we have is a very active quality improvement organization in Rhode Island that is working with the hospitals to develop best practices around reducing their readmission rates. There are two problems with that or there are two sides of the coin. There's no money for the hospitals to do that work and it is completely against their financial incentives to do so. It is financial suicide for a CFO to say yeah, let's reduce my revenue. We're organized around that. So what the effect of the hospital, of the conditions on the health plan contracts, was to put a little juice behind the best practices work, so that the hospitals and the health plans were all working in the same area, and to dovetail it with proposed Medicare payment reforms, which are going to focus on readmission rates. So it's an attempt to align the payers and the hospitals around work that's already been done in the state, and where the Feds are going as well.

Paul Ginsburg

Yeah. So actually, that's one thought I have that you stimulated, is that there's probably real opportunity for mixing things. For example, you know, there's a Medicare ACO initiative, which is going to give general incentives, but there's nothing wrong with having a very specific one on readmissions. It's certainly not contradictory to the broader one. In a sense, it can really focus activity.

Christopher Koller

But if one payer said, I'm going to make it in your interest to do readmission rates, well, I'll take you as representative, that's 10 or 15% of the market and you're getting jerked in a different direction by a different provider, or no direction, so we haven't really created enough of alignment to make it worth our while to do it.

Paul Ginsburg

Yeah, that's a really good point. I think one thing that's really coming through with a lot of speakers is the need for coordination of payers and is it dangerous out there for

providers to do the right thing when only 20% of their patients have contracts that will reward that activity? And Chris, I have one question is that, certainly in my work, I've seen a trend in both the health plan market and the provider market of increasing concentration of consolidation, not violating antitrust laws at all. And obviously, there's some that may be violating, but in a sense, you know, in some of the forces is, it's hard to be a small insurer or a small hospital these days, and those organizations are losing market share. Some of them exit the market or they go under, so the larger ones, market share grows without doing anything that might be challenged. And I know you're speaking for yourself, not the FTC, and I know the law that governs the FTC, I'd always understood that there's a lot of objections within Congress to making any specific changes for a particular sector, but what should state Attorney Generals be doing in areas where you see that competition is being reduced and you don't have the authority to address it?

Christine White

OK, that's an excellent question, and it's true. I think first of all, I should specify that the USDOJ Antitrust Division has responsibility for investigating health plans and insurance

companies for some specific regulatory reasons and I know they get this question a lot as well on the insurance side. My personal view is that what Massachusetts is doing is extremely helpful in this area because it is providing information that's not otherwise being generated through market forces.

Paul Ginsburg

So you're talking about the interesting information on prices that they're putting in.

Christine White

On prices, on quality, letting the consumer see that in some cases, where you appear to be paying higher prices because the large provider appears to have some leverage, it may be worth it to go back and look at the actual quality of information, pricing information, and allow the consumer to have a vested interest in making a better decision. And I think a component of that is the thought that that might help level the playing field and it's beyond my antitrust expertise now, but that's my personal opinion.

Paul Ginsburg

OK, and actually as far as -- since you are an antitrust expert, as far as you know, outside of health care, antitrust authorities in the United States in many other countries, usually are very vigilant, that preventing the publication of price data in concentrated markets, and in fact when I was doing my variations study and I think you've put out a link to it with this hearing, one of the agreements that I -- things that I'd agree to to get data from health insurers for the study, is that I wouldn't publish any specific information unless it was an aggregation from at least three insurers. And this is to protect them against being sued for, in a sense, broadcasting their price schedule. So you know, given the long tradition in antitrust policy of preventing sellers or buyers in concentrated industries from publishing price data, how do you feel about the potential of the data being published in Massachusetts to actually influence the market, you know, leading some of the lower prices? I mean obviously, it brings political heat on the very high price providers, but what about it leadings in low price providers, deciding that you know, maybe we really can increase our rates?

Christine White

That’s another good question and the agencies have actually given a lot of guidance on when it’s appropriate to publish pricing information and a large part, it looks towards masking that information in a way that it’s not saying that it could be disaggregated. In this case, I think we are looking at a state that’s publishing not only the pricing data, but also corresponding quality data and it is coming from the consumers. It’s a demand for consumers. At a fundamental level, the antitrust violation occurs only when competing providers agree that they’re going to fix their prices jointly. It’s not the fact of the information exchange. Having information exchange out there may in some situations create a greater risk of that price fixing, but I think in this case, where the data is being driven by a consumer need, and there’s an intent to really get behind that data and use it, this is probably not the time when providers are going to start to at least explicitly in that kind of price fixing. Is there a risk [tax? 1:35:01] of price fixing is maybe a different question.

Paul Ginsburg

Yeah, but I think that was actually one of the motivations behind my statement of saying, you know, let's focus. It's one thing to get price data for policymaking, to shed light on what's going in the market, but as far as for consumers, you need to give them the prices that they're going to pay, rather than what somebody else is paying. Chris had a comment on that.

Christopher Koller

Yeah, I just agree with the distinction you're making about prices for policy and prices for consumer. Just speaking on behalf of the businesses that are part of our advisory council, what they don't get is the fundamental disconnect when the prices are out there and known for 60% of the payment market, and yet we have this cone of silence around the other 40% or 50%. That is what the private market pays. There's just this policy disconnect and particularly at a time of tight public funds, this great potential for cost shifting, and employers are -- they're pretty tired of picking up what the public doesn't pay or what a provider can shift based on market power. So we've got this disconnect, where it's all, I can go online and

get Medicare and Medicaid prices, but we got the shroud around the private stuff.

Paul Ginsburg

Yes, now Jeff.

Jeffrey Selberg

The readmission discussion was very disturbing to me, so if I could go back just briefly, because it felt like well, not paying for readmissions is somehow a takeaway. The fact is that most readmissions are defects. They're poor care, and there's human suffering around that poor care, so for a hospital to say, well we're not financially incented, the flip side of that is to say, we make our margins on defect and that simply cannot be allowed to continue. And I think the mainstream, or at least the performers we're working with, say it's about how we care for the patient, how we involve the patient and the family in that care, so that they can drive and direct it and our work in terms of improvement is to eliminate defects. Readmissions is a defect. It's not a financial disincentive.

Paul Ginsburg

Even though, still I attributed that statement to the CFO. (laughter)

Jeffrey Selberg

I have. I ran a billion dollar corporation for 12 years, was responsible for lots of patients, and had the Chief Financial Officer who said to me, the balance sheet and the income statement take second place to how we care for people and how we serve the community. That was the CFO.

Paul Ginsburg

Yeah, I mean I think that there's, you know, what Chris is reflecting is the opinion of some people in the industry, probably the hospitals that aren't working with the Institute for Health Improvements. And Laurie?

Laurie Sprung

I would also say that I don't think any CFO, and I've heard the same thing Chris that you have, I don't think any CFO is proud when they say, but we get paid for readmissions today. I don't think anybody is looking to build a business on the ability to bring in more readmissions on more defects, but the reality of the financial incentives is a powerful one and I agree that across our membership, we see the overwhelming majority of organizations running hard at readmissions because it's the right thing to do, but recognizing that their financial performance today is going to be hurt by that and that's a failure in the system that we are penalizing providers for doing the right thing.

Paul Ginsburg

Then find another way to gain financial viability.

Jeffrey Selberg

But I would argue that's a government function. The providers are seeing by the rules that are laid out for them, and the rules have to be changed.

Glen Shor

Well we've got some energy in the room now because I would disagree. I would say that the innovation rests with how patients are cared for and how communities are served and I have, I think, a real issue with the field waiting for someone to tell them how it's going to be. I think we're serving the wrong master in that line of thinking, and I think that's why it's so important to bring the patient, the family, the community, into the effort and al so say, it's about how we care for people that matters.

Paul Ginsburg

Good. You know, one just final thing on readmissions, I think we might all agree that maybe the best thing we would do is

actually, you know, create the financial incentives, so that progress on readmissions actually was a positive for the institution. I've long regretted that the federal approach in Medicare was a penalty approach that for focusing on poorly performing hospitals, rather than a warranty approach of involving all hospitals. Paying a higher rate for the first admission and you know, less or nothing for the readmission with or without regard to cost -- probably better without regards to cost, but risk adjustment. I've got some questions from the audience and want to ask Chris White about how do you feel provider consolidation has impacted the functionality of the health care market in Massachusetts? I guess that's part of your territory. How should the government be involved in consolidation?

Christine White

OK, I don't have experience with Massachusetts specifically to comment on what the outcome of provider consolidation has been. I'm aware, obviously, that there's some significant concerns about consolidation. I know there have been press reports that there have been antitrust investigations. I've not been involved in any of those. There's no question that the

government antitrust enforcers have a very critical role to play in looking at consolidations. We look at them on a daily basis across the country. Most recently, the director of the FTC issued a closing statement about Providence health systems, proposed acquisition and consolidation of two cardiology groups, and we had two hospital merger challenges in Federal District Court until about Tuesday of this week when, unfortunately, we lost one of them. That is one of the top priorities over the FTC is looking at provider consolidation, challenging those consolidations that violate the antitrust laws. One of the problems that we have, I think as an enforcement agency, is that there are a lot of consolidations that slip under the antitrust threshold, and as I said during my prepared remarks, you know, unfortunately antitrust is not a cure all for all market imperfections.

Paul Ginsburg

Thank you. Now I thought of a question while you were talking on this issue of consolidation. You know, of course, there's a very rapid trend throughout the country of greater hospital employment of physicians. And you know, we know there is a potential upside to that, that if you're going to integrate

care, it’s a lot easier having employed physicians or physicians somehow aligned very closely with you than not. Clearly this is going to lead to higher payment rates for at least physicians. We don’t know about the hospitals in the marketplace. Any thoughts about how you resolve conflicts like that?

Christine White

That’s an issue that we’ve grappled with in physician acquisitions by hospitals. Oftentimes, when you look at a hospital that is going out to employ groups of physicians, it’s a vertical consolidation. If the hospital already employs physicians in those specialties and you have that horizontal overlap, it’s more likely to raise antitrust concerns. One of the issues that we’ve considered seriously is what happens to provider rates. If the provider rates are going to increase simply because a hospital becomes the employer of the physicians, not as a result of the consolidation of market power among physicians, antitrust doesn’t reach that issue. So in that Providence transaction that I mentioned earlier, where we actually have a closing statement, Commission staff had determined that by consolidating the two cardiology practice groups, Providence Health System, it appeared would have an

ability to increase the physician rates. I think we can probably speculate that FTC staff had also concluded that even if Providence weren't involved, the cardiology groups that would be merged would've had also inability to increase their provider rates. It's a trend that is ongoing. I've spoken with people at CMS about that. I know they're watching it. We're watching it, and we are continuing to review physician consolidations, including appointment by hospitals across the country.

Paul Ginsburg

OK. If anyone has a comment on that, because I wasn't really focusing just on antitrust policy, but your response was very helpful. OK, I'll go onto the next question. This is for Laurie Sprung or others. How might government organize itself to work with market stakeholders in an objective way?

Laurie Sprung

I'm sorry, I couldn't hear you?

Paul Ginsburg

Yeah. How might government organize itself to work with market stakeholders in an objective way? So I think the question is maybe following up on your focus on critical mass and pairs working together. It really gets into what should government be doing other than in its role as an employer?

Laurie Sprung

You know, the other way that we've seen government be very productive is as a convener of the various stakeholders, so you know, we've heard some across the day about the kinds of sort of multi-stakeholder demonstration projects. We're involved in one in upstate New York, where the state has had a powerful role in convening the various stakeholders -- the hospitals, the physicians, the insurance companies. I'm bringing them all to the table, where each sort of player left their own sort of independence, and may not have been able to come together. The second role then is not only then of convener, but then in really sort of making sure then that the value creation is shared among the stakeholders. You know, going back to the issue that we discussed here around readmissions, part of the

challenge here is that the cost for the coordination -- when that's born by the providers, but the benefit accrues to others in the value chain, that's where the cost incentives happen, and I think the state can play the role then in making sure that that value is distributed among those who created it.

Paul Ginsburg

OK. Yes, Jack?

Jack

Well, I certainly agree with the concept of convener and informer, in terms of having information and data and the ability to evaluate it and then creating learning humanities, where both a public and private sector can try to get an understanding of the facets of the system and how they work with each other and I think that can be an outstanding function.

Paul Ginsburg

Good. Question for Glen -- how has the Connector affected the merge markets? What, if any, obstacles have you seen?

Glen Shor

How has the Connector affected? I mean, the Connector has -- well I guess the way I would put it is, the merger market and the Connector have sort of worked together to broaden access to coverage for our population that was not well served by pre-existing distribution models. The merge market foremost made coverage less expensive for individuals who were shopping on their own. In a sense, there was a small subsidy from small groups to individuals when the market was merged, which led to particularly around the inception of health reform, some pretty significant drops in premiums for individuals who might otherwise have been priced out from coverage -- bring in the Connector, which was able to put those more affordable prices at the tips of individual's finger towards Commonwealth Choice program, constructing a very easy to use online shopping experience, with strong participation and support, particularly in this area of health insurance carriers, and I think between

the more affordable rates and the easy online shopping experience, it’s no surprise that we had, among the 400,000 newly enrolled in coverage in Massachusetts, pretty significant gains in non-group coverage and a very significant portion of it, probably around 40% or so last I checked, was concentrated at the Health Connector.

Paul Ginsburg

Good. Question for Chris Koller. How did the premium rate regulation translate to provider rates? Was there a change in the medical loss ratio subsequent to the denials or regulation of premium increases?

Christopher Koller

So our medical loss ratio is going up. It actually -- one of the benchmarks we use is Massachusetts. Our loss ratios are not as high as they are in Massachusetts. We’ve been able to do admin costs, look benchmark admin costs on a provider per month basis. It turns out you get some pretty reliable state-to-state comparisons on that, and then you can use the rate process to

drive the admin costs down, so we've been working on that, but our insurer admin costs are higher than in Massachusetts. That could be a population issue. We have a smaller base. From a provider rate standpoint, because we don't have a regulatory authority of our provider rates. We're very clear about that. We don't regulate the providers regarding the health plans, but we're pretty clear that the effect has been to raise evaluation and management codes and to suppress all other CPT codes, which is consistent with our goal of making a more attractive market for primary care.

Paul Ginsburg

OK. We've got about a minute or two left and any final comments by anyone on the panel? Yes, (inaudible).

Q

I'd like to welcome members of my team here and I hope you guys -- I'm actually going to mention their names, if I get my list in front of me, if you don't mind.

Paul Ginsburg

OK, why don’t you work on that? If anyone else has -- and then I’ll go back to you for the last. OK.

Q1

Just my learning here in the time that we’ve had has been significant and I really do think that that combination of regulation and market forces being aligned in many different ways, tests have changed to promote to promote that value creation in the field is what I’m coming to in terms of the answer and Paul, I think you said it well in your presentation.

Paul Ginsburg

Thanks. Well this is probably a good time to stop. Oh. (laughter)

Q

From our finance team, [Jean Yang and Amanada Ende? 01:51:26]. From our policy team, Caitlin Kennedy and [Camy Corrigan? 01:51:29], Dick Powers, our communications director. From our Commonwealth Care team, Steph [Crowback? 01:51:36], Nicky [Conti? 01:51:36], Jenn [Flint? 01:51:37], and Tatiana [Muereva? 01:51:39], and our Assistant General Council, Ashley [Hade? 01:51:42]. I single these people out, just because many of you work with the Health Connector. These are the faces of the Health Connector and so far as you think we've done anything good, it's really a credit to these folks who work really hard. Welcome.

Paul Ginsburg

I'm glad you're --

Q

If I missed anyone, I'm really sorry.

Paul Ginsburg

I was afraid you were going to say they were all involved in writing your statement. (laughter)

Q

No, they yeah...micromanaged some things.

Paul Ginsburg

Good, well let’s give a round of applause to this panel. (clapping)

Jody Gittell

Thank you Doctor Ginsburg and thank you panelists. We’re actually now going to begin the public testimony period of our hearing process. I would like to call [Brian Rosman] from Health Care For All. We’ll actually just wait a few minutes,

since the agenda said the public testimony period will begin at 3:30. We'll just wait a few minutes for the rest of the people to arrive, who have signed up to testify.

Amy Whitcomb Slemmer

Commissioner, thank you so much. I very much appreciate being able to come and make a statement at the end of these hearings. We've had a remarkable time here this week and are grateful to you and your talented staff and the committed and dedicated staff members from the Attorney General's Office, who have truly been inviting us to have a conversation about what is driving the escalating cost of health care in the Commonwealth. I'm Amy Whitcomb Slemmer. I'm the Executive Director of Health Care For All, and I'm pleased to be able to spend just a few minutes this afternoon summarizing a bit of what we've heard and then taking this opportunity to talk about what we, as consumer advocates, are committing to do in Massachusetts during the next year. We've seen, over these last four days, that the costs of health care are having a dramatic impact on consumers in Massachusetts, and that the costs and the money that we pay for our health care premiums and the care that's delivered and received is not necessarily tied to the value that we place on that care, that

we as consumers place on that care. And we very much appreciate the thoughtful testimony that's come this week from all sectors of health care industry and we, as consumers, would like to say that we're fairly desperate for the impetus. We feel desperate to move toward a more comprehensive solution to addressing the costs of health care and reorganizing the health care system, so that it delivers better value. It is incentivized. We pay for care to keep us well, rather than what we have now, which is a fee-for-service system that, as you've heard from this morning's panel and discussions earlier in these hearings, is not necessarily what's best for consumers or for the overall health care system. So this morning, Reverend Herman Hamilton and I, Reverend Hamilton from the Greater Boston Interfaith Organization and I as a representative of Health Care For all, joined together to ask for a timeout on health care cost increases. We have said that for a year, we want our insurance premiums to stay stable, not to raise for a year, while the rest of join together to work hard to address what the overall cost drivers are. We appreciate that this will require some sacrifice and we believe it's in the tradition of Massachusetts moving toward coverage for almost everyone, we worked hard in the spirit of shared responsibility. And we at Health Care For All and GBIO are here to say we're going to work together again, in the spirit of shared responsibility and frankly, shared

sacrifice. We will be out in the communities educating consumers about the best way to access their health care system. We are also going to hear stories from people who are having challenges in getting the full benefit of the money that they're investing in our system and what they need for their overall treatment. So we'll talk about smart ways to access the system, and we're going to be pushing hard to work toward what the governor started these hearings out calling for, which is comprehensive legislation that will reorganize our health care system, so that we'll be able to drive value and not volume of the services we receive, so that we'll incentivize our overall care and so that we'll save money in the process while getting better quality care that we all know that we deserve. So I very much appreciate these conversations. I can't tell you how informative this is. Thank you, Commissioner, for kicking us off by referring to this series of hearings as Health Care Cost Boot Camp. That's how Health Care For All sees it. We also see it as unique in this country for the Commonwealth to spend this many hours, providing this much public information, so that we can have some transparency, understand what is driving health care costs and see the opportunities to make true improvements in our system. We've done it, we've had success in providing coverage for everyone, and now we ask everyone to join with us together, shared responsibility, shared sacrifice, to do the

next file frontier, phase two of health reform, which is addressing all the other care we receive and reducing the costs that we all have to spend. So thank you very much for this. I appreciate it and congratulations on the conclusion of a very successful four days. Thank you. (clapping)

Jody Gittell

Chuck Green from Greater Boston Interfaith Organization.

Chuck Green

Hi. I run a small construction and remodeling company in the Framingham area. We have a health care plan that we've had a little under two years. Last June, we were paying a rate that was jacked up in September by 18%. In April of this year, it was jacked up again. We're now paying 47% more than we were one year ago at this time. We had no major claims. I'm in very good health. Never spent a day in the hospital since I was born. I do not see why this is happening, and no explanation offered, just it felt like -- well, the rates were increased

subtly. Well, it's been a real strain. Construction has been way down these last two years, and we are struggling to do the right thing, which is to carry the health insurance. We have a deductible for my wife and myself, the two who are covered. We are at the rate of $21,000/year to the insurance company through my company. It is very, very hard. We're really struggling. Last week, my wife had to have a minor ultrasound procedure at the Regional Hospital. She went over, gave them the health card -- oh, you haven't met your deductible. You're going to have to pay right now before you can have the procedure. Well, she really hesitated about taking out the credit card and doing that. And now, she's hesitating on follow-up care. I have to just urge her, your health is everything. Just forget about it. We'll get by somehow. We're really struggling and we're paying more than twice what we pay on our mortgage for the health insurance. That's principle and interest, not the real estate taxes. The real estate taxes are 40% more for the health coverage. And I don't feel like we can use that when we hit that rollover every year, needing to get it to the deductible. It hurts every time. In a certain way, more [wrong? 2:00:40] feeling than when we have to pay that monthly premium. I put off three months. I don't know if you noticed I was just slightly limping coming over here. I put off for three months getting treated. This morning, I saw a physician for a damaged

Achilles' tendon because I just couldn't come up with the extra. That's not right. This feels more like I've been dealing with one of the sleaziest Wall Street firms than with a really responsible health care insurer. I don't get it. $21,000 and it feels like we don't have any coverage? Thank you. (clapping)

Jody Gittell

Reverend Hamilton from GBIO.

Herman Hamilton

Good evening. Let me also add my thanks along with my colleagues aiming for the hearings that have been held over the course of the last four days. Let me just say a few words about GBIO's perspective on this matter. We applaud Governor Patrick's administration for recognizing the urgent needs to

reduce overall health care and the commitment of insuring access and affordability for all. Massachusetts has successfully delivered health reform, providing insurance coverage for a little over 480,000, previously who were without health care coverage, and we did that while limiting the expenditure from the state budget to about 1% overall increase. Why did GBIO engage in this campaign? We're engaged because we have a moral obligation to ensure the economic and medical health by a community. We're engaged because our congregations and non-profit members are hurting from high premium increases and we're engaged because our members are hurting from the stories you've just heard from Chuck. We're engaged because business owners are hurting and ultimately, the escalating cost of health care threatens the ability of our Commonwealth and municipalities to provide necessary social services to all. Let me conclude by saying then, as Amy has pointed out, that we stood on the steps of the Beacon Hill State House this afternoon. We've called for zero percent premium increase for the next year until we find a long-term solution. We presented a challenge to the insurance industry and the hospital providers group. They should tighten their belt to do whatever it takes, whatever that means -- reaching into the billion dollar reserve funds that the insurers have, and it also means in a predominantly fee-for-service environment that still exists, hospitals will have to receive

less and give more. We presented a challenge to (inaudible) employers. We used the mic and power of their negotiating capacity to stand alongside of us and to the government, we have said ultimately, keep the pressure on until we reach a long-term solution. Let me conclude by saying this. It is not our intent to demonize the leaders of the insurance world or the hospitals or our doctors. We know most of them, and I think many of them if not all of them, they understand that despite their short-sighted policies that put us in this situation, they're very serious about trying to help get us out of here. But it's going to need to persistent pressure of government and consumers and all of us working together to see that through, and we are not unaware of how complicated the situation is. Those who tell me that this can't be solved unless Medicaid reimbursement is raised. Well if that's true, then we've got to make sure that's part of the solution. There are others who've said, we need tart reform because defensive medicine is driving the cost. If that's the case, then that has to be part of the solution. And there are others who remind us how mental health services have been victimized in the name of health care cost control. We need to be sure we fix that, so this is quite complicated, but as I said on the steps today and I'll say it here when I go to my seat -- five years ago, I used to quote a passage out of Christian scriptures, when we were fighting to get what was then

the impossible task of Chapter 58 passed. I used to quote that scripture from Ephesians that says, “God is able to do exceedingly abundantly more than we can ask or even imagine, according to God’s power at work within us” and what we once couldn’t imagine in this state has been accomplished in Chapter 58 because of shared responsibility, shared sacrifice among the stakeholders. Perhaps some can’t imagine the kind of sacrifice that’s going to be needed to bring cost control, but the nation is depending on us getting this right and I’m saying, we can imagine it, the government can imagine it, self employers can imagine it, and ultimately, the insurers and the hospitals and the doctors -- they’re going to have to imagine it too and I think they have the wield and the imagination to do it. If we keep working together, I’m hopeful that in the not too distance future, this problem will be solved and we can get onto the next challenge. Thank you very much. (clapping)

Jody Gittell

I would like to call Steven Bradley from Bay State Health.

Steven Bradley

Thank you, Commissioner and Attorney General, for holding these hearings. I've become quite familiar with the Mass Pike, from Springfield to Boston because as sort of the James Taylor song goes for most of this week -- my name is Steven Bradley. I'm the Vice President of Government Community Relations and Public Affairs at Bay State Health in Springfield, Massachusetts. Prior to that, I was employed for 23 years by the Commonwealth of Massachusetts as a former Regional Director of the Department of Mental Retardation, which is now the Department of Developmental Services, and as a Chief of Staff for the Mass Senate Committee on ways and means. I just wanted to be clear that Bay State Health is committed to transforming our system of care. We're actively working on the development and on the expansion of key infrastructures required to build an apprehensive, highly coordinated, patient centered, high value system of health care leading to the likely formation of an ACO. We have more AQC level three patients that are in medical homes in the Commonwealth than any other organization. We're building a robust IT system. It's in the top two percent in the country and we all operate Health New England, which is a highly

reputable HMO and so we have a long history of being able to manage risk. In terms of value, Bay State Medical Center, which is our flagship hospital, is the lowest cost, high quality, academic and tertiary medical center in Massachusetts, with an inpatient discharge average cost of approximately $8,600 per patient per year. That's half the cost of the highest cost, Boston-based, academic and tertiary medical center, and 60 to 70% of the cost of other Boston care hospitals. Now we're very concerned that we're getting caught up in sort of what is a Boston market problem that you know, the Commonwealth is attempting to solve. What is the risk here, as we go through the transition to this population-centered health care, is that we're the Western Mass campus of Tufts Medical School, and we've trained one-third of all the physicians practicing in Western Massachusetts. We have been the second largest Medicaid provider, inpatient and outpatient, for many years with over 22% of our patient mix being Medicaid. We have three large community health centers that we're supporting. We are the largest OB/GYN clinic in western Massachusetts. All four of these entities are primarily Medicaid patients. We're the largest employer in western Massachusetts with over 10,000 direct employees and another 7,500 indirect jobs, so that totals 17,500 jobs in western Massachusetts. We generate $2.6 billion of economic activity, with approximately 10 cents of every

dollar of economic activity in Hampden County, which is one of the poorest counties in Massachusetts, which is the home to Springfield and Holyoke, two of our older cities, 10 cents on every dollar of economic activity generated by the efforts of Bay State Health. We spend over $850 million on goods and services annually and half of that is purchased in Massachusetts. And as a high quality, low cost, tertiary hospital, we've been on the leapfrog list of top 40 values in hospitals, teaching hospitals, in the country for the last four years. We're actually being penalized, you know, by the activities that are necessary to write the Boston market and the market dysfunction that's there. These dysfunctions to not exist in western Massachusetts. We don't receive hundreds of millions of dollars a year in subsidies off the top of the state Medicaid waiver, through the IGT, like some of our peers do. Even though we're a safety net hospital and serve, by far, the largest number of Medicaid patients, so why am I mentioning this? Well, I'm mentioning it because we are a high value hospital in western Mass, and even though we're a teaching and academic medical center, we're getting lumped in with all the Boston hospitals, and we're being compared pricewise to our community hospitals that don't actually have a teaching mission and a research mission and we're being tiered at a very high level and we're having copayments to put on our patients of up

to $1,000 to discourage them from coming to our hospital. So as a result of that, we are now having the worst financial year we've had in 20 years. Our admissions are down by 8%. 70% of our insurers, our payers, are either cutting our rates or freezing our rates for the second year in a row, and as a result of that, we are going to have to trim $100 million of cost, you know, from our $1.6 billion budget, our $1.7 billion budget. So in order to become competitive under these new rules, and if rates get frozen for the next year as has been recommended, we're expecting to have to reduce our work force by up to 10% over the next 18-24 months. That's 1,000 jobs that average $68,000/year in one of the poorer cities of western Mass. So the question isn't, are we willing to be part of the leadership to move to this next type of service? We are and we are doing that. The issue is, are we going to survive long enough during the transition to be able to be part of the future? Thank you. (clapping)

Jody Gittell

Barbara Rabson from MHQP.

Barbara Rabson

First of all, I want to thank the Attorney General's Office and the Division of Health Care Finance and Policy for the opportunity to testify this afternoon. My name is Barbara Rabson and I'm the Executive Director of the Massachusetts Health Quality Partners. The Mass Health Quality Partners, or MHQP as we call ourselves, is a nonprofit broad-based coalition of physicians, hospitals, health plans, purchasers, patient and public advocates, government agencies, and academics working together to achieve improvements in the quality and affordability of health care in Massachusetts. In the last 15 years, MHQP has grown to be one of the most trusted names in measurable, evidenced face, quality care information and transparency in Massachusetts and in the nation. For the past two years, the Attorney General's office and the Division of Health Care Finance and Policy and the Quality and Cost Council have been examining the drivers of health care costs in developing recommendations for sustainable solutions, and it's become really increasingly clear that moderating health care

costs will require a concerted and collaborative effort by all of the states, public and private stakeholders. We've been hearing a lot today about the government's role, but clearly there is organizations like Health Care For All and Greater Boston Interfaith Council and MHQP, who have a lot to contribute and you can leverage our efforts. There are no simple or quick solutions. There are however, immediate opportunities that can result in higher quality, patient centered care, while cutting waste and inefficiencies from the health care system. MHQP is well-positioned to help physician groups assess and reduce practice-based variations in the use of health care services that impact the cost, quality, and outcomes of care. Since 1973, Doctor John Wennberg and many other researchers have found that much of the variation in clinical practice is attributable to physician preference, habit, and training, rather than patient preference, severity illness, or outcomes of care. Currently, MHQP works with the state's health plans in with more than 180 physician organizations, representing some 4,000 primary care providers, to develop performance reports and delivery of preventive and care services. MHQP has found that while Massachusetts physicians have made impressive progress in improving significant variation, in improving the quality, there are significant variations in performance that remain for some high cost conditions and types of care. Variations may indicate

either overuse of services that do not improve health care, or underuse of preventive care services, that can improve health and help patient avoid the need for more costly types of care. The latest MHQP data shows significant variation among Massachusetts medical groups for managing such conditions. For example, there is a variation in measures of overuse, such as inappropriate image tests for lower back pain, or underuse, such as screening for cholesterol in diabetics patients. So statewide, there is a 35% point variation in the appropriate use of managing for lower back pain. So that means there's this much variation in physicians are currently practicing. There's also a large variation in how many docs provide cholesterol screening for diabetic patients. So we know there's variation in care. We've heard a lot about all care is pretty good in Massachusetts, and when you drill down to the practice sight level at the individual level, there are very significant variations. Some have been tightening over time, which we feel very good about, but there's still that remain. So in terms of how do we -- what can we do about this? Massachusetts will have a powerful new tool available for examining utilization cost and quality. When the Division in Health Care Finance and Policy completes the development of the all payer claims database, or the APCD, it will include medical, pharmacy, and dental claims and encompass all types of coverage. We really need to be sure

that we balance the time and energy being expended on how to restrict access to the APCD, with a focus on how to utilize the APCD to equip our delivery system with the information needed to improve the understanding of how care is delivered and how it can be improved. Since its inception, MHQP has earned the trust and support of the state's medical community by involving physicians in its measurement and reporting process. As the APCD nears completion, MHQP offers an unbiased neutral mechanism through which all of the key stakeholders -- physicians, hospitals, health plans, employers, consumers, to be engaged in making sure that data is transparent and actionable. Specifically with action to the APCD, MHQP would be able to engage the health plans, providers, payers, and patients, in a collaborative process to establish priorities for practice pattern variation analysis. What is it we should work on? We've heard a lot from the previous panel about, if every payer goes off and sets their own priorities, it's really quite challenging to focus and so we could do this collaboratively. We can adopt an analytic model developed and tested by Blue Cross currently to standardize comparative data across the health plans using the APCD. We can use existing relationships and infrastructure to share variation analysis with the physician organizations in a respectful way, which is key to having physicians change their behavior based on the

information. We can lead a collaborative process for setting performance standards for targeting conditions that are community-based standards, so that everybody knows what the care should be in the community. We can help providers analyze the business case for improvements to find the most cost-effective approaches to changing practice patterns. We can equip patients to become more active participants in shifting health care system and we can also monitor the impact of changes on patient experience throughout this. So an approach that identifies specific unnecessary practices and then engages physicians in changing them, offers an excellent immediate opportunity to address the urgent need to make Massachusetts health care more affordable. Thank you very much and I apologize for going over. (clapping)

Jody Gittell

Ken Farbstein?

Ken Farbstein

I’m Ken Farbstein, a patient advocate with a private practice, and an author of a new book, *Getting Your Best Health Care: Real-World Stories for Patient Empowerment*, published by the Professional Patient Advocate Institute. Thank you, Commissioner, for the opportunity to learn the last few days in these hearings, and to speak. Reverend Hamilton said that God brings about more than we can imagine. Let's imagine what payment reform will look like in practice. On Tuesday, Amy Slemmer stressed the importance of transparency, as did most of yesterday’s afternoon’s panel of speakers. So what does transparency look like in practice? In Pennsylvania, where they've had mandatory reporting of serious reportable events, that reporting has now, they can confidently say, decreased wrong site surgery, according to Mike Cohen, the head of the Institute for Safe Medication Practice. That's pretty good for patients' quality of care. And it reduces costs, because there's no need for physical therapy, prostheses, follow-up visits, and so on, to try to make up for the mistake, plus the cost of doing the operation right the second time around. What else does transparency look like? Harold Miller told us yesterday about how critical it is to get clear information on

price and quality, as did several of the speakers today. A one-pager given handed to the patient before any surgery, stating the likelihood that a repeat operation will be needed, the number of similar operations that surgeon has done before, the alternatives to surgery, and the cost to the patient, will be useful information in making that decision. When we brought my dog in for a surgical decision about a lump in one of his front elbows, the veterinarian gave us very clear information about the risks and the alternatives and the costs. Her information was much better than the explanations I had received about my own surgical decision for my eye and for my sinuses. Fully informed, shared decision making will get many people to choose less costly alternatives to surgery, as I did twice. The Cochrane Collaborative documented the cost savings in its most recent systematic review of 58 articles in the medical literature found significant savings. Impartial patient advocates can discuss end of life decisions that are based purely on preserving dignity and the quality of life. Family members will often prefer hospice care, which is more humane and less costly than "death by ICU." My father had a long gallant struggle with Parkinson's Disease. At the end, he, and we, chose hospice care. That was definitely the right decision for his dignity and the quality of his remaining life. It also saved money for the taxpayers. Yesterday, Harold Miller told us

there are three ways to reduce costs: prevention, preventing hospitalization, and more efficient hospital care. What do they look like? Prevention, you know about. Harold Miller also mentioned avoiding hospitalizations. Last night I went to a medical home meeting. There were pediatricians, a nurse practitioner, another nurse educator, the office manager, three parents of kids in the medical practice, and me, with pepperoni pizza, Diet Coke, and champagne to celebrate a journal article to be published on the successes of the medical home. They showed a homemade video teaching parents about a new alternative to stitches when their kid gets a deep cut. They teased the nurse practitioner who was the star of the homemade video. Their laughter, and their warmth, is a key ingredient of the medical home. That's what home looks like. The video is about something called DermaBond. So if you imagine a glue stick that the doctor would use to seal a deep cut, instead of stitches, so those kind of cuts can then be treated in the doctor's office without an E.R. visit. No stitches need to be removed in a later visit. So these, and many other changes, have enabled this medical home to reduce their E.R. use among their kids over the last four years by one-third, and they've used a lot to harbor up with the MHQP data. That's what a medical home looks like. And third and last, Harold said that costs are reduced with more efficient hospital care. My mother had complained of

radiating neck pain, so I had brought her to our small community hospital's E.R. She was given a telemedicine consult with a doctor at BIDMC in Boston -- a 2-way TV hookup that impressed her greatly, and promptly ruled out a stroke. That's what efficient hospital care looks like. A patient advocate who is fully independent and trusted can help patients and their families make the difficult decisions about how to get their best health care. That’s what payment reform will look like. (clapping)

Jody Gittell

Thank you. Paul Swoboda from UMass Medical School.

Paul Swoboda

Hi. My name is Paul Swoboda, as just said. I’m from UMass Medical School’s Center for Health Care Financing, which is a

part of the Commonwealth medicine part of the school. What I'm here actually is to talk more about a much earlier part of my career and the experiences in the 80s of the regulation of health care prices that took place by the predecessor in Division Health Care Finance and Policy, which was the rate-setting commission. And I think some of the benefits of history that there may be for challenges that are now being faced. By just a CNN version of the history and some of the parallels we have now, the rate regulation of hospital prices actually began in this state in the mid 70s in reaction to high rapid increases and hospital prices. And the reaction that administration legislature at the time did was a freeze, while another plan was worked out, which is something we heard about just earlier today as a technique, and that led to the institution of price controls on hospitals, which was known as the 409 program. It applied price controls that really just affected the charge payers, the commercial insurers. That eventually led to a system of a much more involved system of an all-payer system in Massachusetts, where all payers were participating, using one particular model of a perspective payment. In the parallels to here, right now the emphasis is on the damages or the problems that are caused by fee-for-service, which I believe are very real and it is a very, very necessary focus. At the time, the concern was the differences in the incentives of the different

aspects of payment system, including that there was a lot of cost-based reimbursement and that, you know, that basically incentivized cost increases and different payment levels. That was what was the focus, so the response at that time was to establish an all-payer system that actually says you had really had intervention into the market. In the 70s, it was the first. It kind of evolved over time, improved, and led to a period of years in which there was a reduced rate of increase in prices. The parallels of that time and then actually, just to go back, that led to eventually -- even though it was a somewhat successful model, we went back to the market forces when market became more important. That's where we've been for the last 20 years. So specific lessons from that period of time that I think may help apply -- one of the problems that there was with the systems that were put in place were the differences among the providers in what their costs were, just as we hear now, the differences in provider variation and what they're being paid by the insurers. One of the things that the interventions that were made at that time did not take into account properly was these different starting points and it was a lot easier for certain other providers to deal with the new system than it was for others because you didn't have an equal starting point, just as we have now with very different payment rates. So one, I think, lesson from that time is to be very, very conscious of

how you go about where you're starting from as you develop a different model, and for example, with the movement to ACOs, if you have a system with shared savings, the starting point of providers starting at, you know, very different points, make it easy to figure out who the winners and losers will be in the system. So I think one of the big lessons from that time is to be very, very conscious that you just don't use a starting point that is not adjusted for the differences in the system. And just one other aspect of that time in the relevance to now -- there was a question earlier today about when is it time for regulation, when is it time for market, and should we be holding regulation in the closet with the stick to come out when needed? From my perspective, being involved in health care for 30 years in Massachusetts, is I think the time is now for regulatory mode and because of the movements that there are in, for example, in the ACO which everybody is putting a great deal of hope in, which I believe is important, but in that model, the need for regulation based upon market power is so fundamental and the role of the AG is so fundamental for that to properly work, that it really, really, I think, it is time now, but it's also time to make sure that the regulation based upon market power is the core of moves forward from this point. Thank you. (clapping)

Jody Gittell

Thank you. We have two more speakers. David Mattioto from MABHS?

David Mattioto

Thank you. My name is David Mattioto and I'm the Executive Director of the Massachusetts Association of Behavioral Health Systems, and I appreciate this opportunity to testify. I represent 49 inpatient behavioral health facilities throughout Massachusetts, which is the overwhelming majority of the inpatient system, and I don't know how much you've heard from mental health and substance abuse, so I thought I'd come down today and offer a little, make three or four points. One is the background, two is what is the status now, and three what are we looking forgoing forward. My hospitals, which is the overwhelming majority of the hospitals in Massachusetts, see about 60,000 patients annually. Currently in Massachusetts,

there are a total of 3,000 beds for behavioral health. That includes substance abuse and mental health. 630 are in the DMH system, 2,300 are in private hospitals, of which 60% of those are in general hospital units and 40% are in freestanding psychiatric hospitals like McLean and Bournewood and Arbour, et cetera. The breakdown is 1,700 are adults, 347 for geriatric folks, older, that need psychiatric care, 287 child, and we've been remarkably stable, believe it or not, over the last seven years. The beds, at least in our system, have remained very consistently -- I look back to 2004 and we were right around the same numbers. Of course, the DMH just closed about 300 beds in that same time period. And since our systems are interrelated, we strongly hope the DMH does not have to close any more additional continuing care beds, which tend to be a few months. Our length of stay is eight days on average. We're very heavily public payer dependent -- 38% Medicare, 29% Medicaid, 33% private and other. Most of the Medicare is SSI disabled, although we do have geriatric. So, where are we now? We're a very fragile system. We believe we're underserved, underfunded, and over-managed. People can wait a long time in an emergency room to get a bed. Once they get into our units, we can have great difficulty finding a discharge physician to take and evaluate that person for their medicines on an ongoing basis, and there can be waitlist for DMH referrals to state hospitals.

We currently have a waitlist of about 30 to 50 people waiting for a DMH bed. So, we're in a very fragile situation and we hope this commission really looks at behavioral health. We were very happy that the Governor's Bill House 1849, has strong recognition of behavioral health in a number of provisions. We're also going to be testifying before the legislature on that and we've given them, actually, some written testimony. I'm going to do it verbally. So that's the current status. The administration seems to recognize behavioral health in terms of the importance of including it going forward. What do we think and hope this commission will be guided by as you look at it and try to figure out what should happen in the future for behavioral health for major principles? One, please make sure behavioral health is adequately funded. Two, make sure that necessary benefits are maintained in any kind of new network or system. Three, we need adequate number of providers in any delivery network. Make sure that the ACOs or whatever kind of system we have has enough providers. And four, please make sure that the Federal Parity Law for Mental Health and Substance Abuse benefits is fully implemented in Massachusetts. So, in conclusion, behavioral health has been treated differently by society in the health care delivery system for too long. We've been carved out, rather than recognized as an integral part of the health system. In order to confront the numerous issues in

this field, behavioral health needs to be a priority of government, insurers, and providers. We hope these hearings have demonstrated a need for this and offer our assistance and hope this commission will make behavioral health a high priority. Thank you. (clapping)

Jody Gittell

So the last person signed up to provide public testimony is Eric Linzer from MAHP.

Eric Linzer

Thank you and for the record, my name is Eric Linzer. I'm the Senior Vice President for the Massachusetts Association of Health Plans. We're a non-profit trade association that represents 13 health plans that operate here in Massachusetts in providing coverage to 2.3 million Massachusetts residents. I

would like to commend the Division and the Attorney General's office, not only on this week's hearings, but on the comprehensive reports that both your agencies have provided, as they've really shown a spotlight in terms of the factors that are driving health care costs. Essentially, both reports have found that increases in health care premiums have been driven in large part by increases by the prices providers charge and that the most expensive providers don't necessarily provide the best care. Reports findings in these hearings underscore a simple fact that if we're going to address rising health care costs and do something about getting cost under control, then potential interventions need to get at underlying costs. While we're committed to addressing and working with state leaders, policymakers, other key stakeholders, to accelerate the movement away from fee-for-service to a system that improves the quality of care and reforms the payment system, we believe that unless we deal with the market powers, certain providers, and the prices that they charge, then payment reform will not be successful and ultimately will not be able to control costs. What this means, as was talked about earlier this week, is that ultimately, we need strategies that can correct the existing market dysfunctions, and while we move in the direction of payment reform, we also have to do on a parallel track, to make sure that we're addressing these market dysfunctions. As this

week’s hearings and reports ultimately provided a very strong foundation for what’s going to come next, which is going to be the provider pricing commission, and we hope that this week’s hearings, the reports that will come from this and the previous reports, will lay a strong foundation for looking at and developing strategies that ultimately will deal with the market dysfunction, the variations in prices paid to providers, and ultimately that should lead to addressing the cost of health care for the small businesses and other employers and consumers in the state. Just once again will I commend your agencies on the hard work that you’ve done. We know it’s been yeoman’s work and it’s been a tremendous amount of work and again, I just want to congratulate you on how important this work has been. Thank you. (clapping)

Seena Perumal Carrington

I feel like all of you deserve a prize for sticking to the very end, so thank you once again. So the goal of these hearings was to elicit feedback and foster public discussion from key stakeholders, but besides simply focusing on the problem, these

hearings were intended to unearth actionable solutions from health care experts and stakeholders that could help mitigate cost trends in the Commonwealth. So in the information, the ideas, and the solutions presented during these four days, will serve as the basis for the development of a report by the Division and that it's been informed the recommendations that we give to the legislature on what types of public policy and industry actions are needed in order to collectively mitigate health care cost growth. The report should be completed an delivered to the legislature, I would estimate by some time in mid-July and I would be remiss to conclude these hearings without thanking each witness and presenter that participated in the proceedings. I appreciate your time, thoughts, and willingness to openly and publicly discuss these issues and I also want to thank Bunker Hill Community College for so graciously hosting us and providing us this space. And I also want to acknowledge the work of all those people who've made these hearings possible, both our consultants as well as the Division team, and I also want to thank our partners both at the Division of Insurance and the Office of the Attorney General, partners and friends without whose assistance and commitment we would not have been able to host these hearings nor better understand the drivers of health care cost trends. So lastly, if you haven't gotten sick of seeing our faces yet, a number of

us are going to be going to Max & Dillon’s down the street to celebrate the end of four long days and all of you are invited to join us, so I’ll see you there. Thank you. (clapping)

Tom

I think that teamwork has also been demonstrated by the interpreters. Can we get a round of applause? (clapping)

Seena Perumal Carrington

Thank you, Tom. That’s right.

END OF AUDIO FILE